Parent

The Maryland School for the Blind

3501 TAYLOR AVENUE BALTIMORE, MARYLAND 21236 410-444-5000

EMERGENCY (911) TRANSPORTATION
and STUDENT INSURANCE INFORMATION
Health Center - School Year 2026-2027

STUDENT NAME: ______________________________

PARENT/GUARDIAN: ______________________________

ADDRESS: ______________________________

PHONE: ______________________________

The Maryland School for the Blind is hereby authorized to transport, or have my child transported, to the hospital in the event of an emergency.

The 911 dispatcher will determine which area hospital my child will be transported to under the existing circumstances.

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PLEASE PROVIDE A COPY OF THE FRONT AND BACK OF THE INSURANCE CARD
OR
COMPLETELY FILL IN THE STUDENT'S HEALTH INFORMATION BELOW

Card holder's name: ______________________________

Card holder's address: ______________________________

Card holder's phone number: ______________________________

Card holder's Employer: ______________________________

Patient Relationship to card holder: ______________________________

Insurance Carrier Name: ______________________________

Insurance Carrier Address: ______________________________

Policy Number: ____________________ Group Number: ____________

Group Name: ____________________ Effective Date: ____________

MEDICAL ASSISTANCE/MCO INFORMATION

MDMA Number: ______________________________

Member/Policy Number: ______________________________

______________________________ ____________________
Signature Parent/Guardian Date

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Printed Name of Parent/Guardian

PB/LB/cic:4/25/25